SENIORLINK™

500 Boylston Street
Suite 640
Boston, MA 02116

t . 617-456-3758

www.seniorlink.com

January 28, 2013

Delivered via email

To: Lou Ann Owen, Medicaid Deputy Director, Louisiana Department of Health and Hospitals

Fr: Matthew J. Lockwood Mullaney, Vice President, Business Development
Rachel Richards, Vice President, Government Relations

Cc: Tyron Picard, The Picard Group
Mike Michot, The Picard Group

Re: Seniorlink Response to RFI regarding LTSS for Persons Enrolled in Louisiana Medicaid

---

We appreciate the opportunity to share Seniorlink's views and thank the Department for inviting comment on this important subject. We begin by sharing our perspective (pages 1-3) on why a new approach to managing Long-Term Services and Supports (LTSS) is so vital. We then share brief, specific comments (pages 3-8) on each of the topic areas identified in the RFI. We close with a brief summary of our company and our experience (pages 8-9).

SENIORLINK PERSPECTIVE

A new approach to traditional care management is needed for the complex populations that Medicaid is enrolling into managed care in large numbers around the U.S. for the first time. There are two simple reasons driving the need for a new approach: the people enrolling and the capacity of the providers on which they depend.

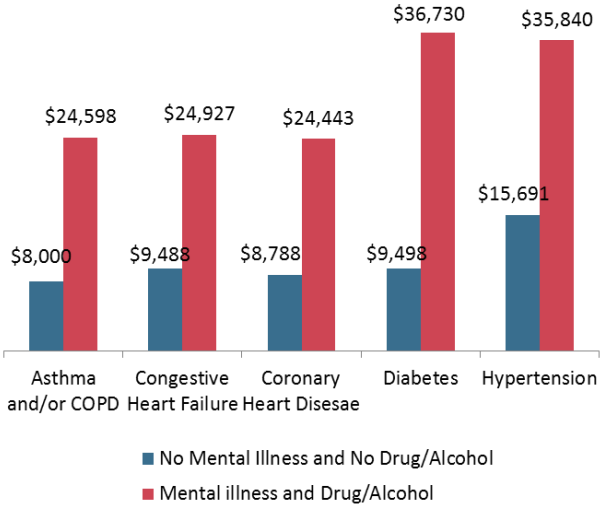
Much has been written about the complex needs of dual eligibles and similar consumers who are now eligible for Medicaid only. Dual eligibles have lower incomes, less education, greater diversity, and poorer self-reported health status than other Medicare beneficiaries on average. Multiple medical conditions among duals lead to greater complexity and higher costs to Medicare (Figure 1, left panel), and contribute to higher so-called custodial costs (e.g. nursing facility costs) to Medicaid. Also well-known is the compounding effect that mental illness and/or substance abuse have on cost and on the challenge of successful care management (Figure 1, right panel).

Figure 1: Medicare-Only Cost of Duals with Co-Morbidities and Mental Illness/Substance Abuse

Annual Medicare Costs Alone Top $45,000 for 10 Highest Cost Co-Morbidities

Dementia, HIV/AIDS	$60,145
Asthma/COPD, Chronic Pain, Chronic Renal Failure/ESRD, CHF, CHD, Dementia, Hypertension, Mental Illness	$58,617
Cerebrovascular Accident/Stroke, Chronic Renal Failure/ESRD, CHF, CHD, Dementia, Hypertension, Mental Illness	$57,905
Chronic Pain, Chronic Renal Failure/ESRD, CHF, CHD, Dementia, Hypertension, Mental Illness	$57,857
Asthma/COPD, Chronic Renal Failure/ESRD, CHF, CHD, Dementia, Hypertension, Mental Illness	$53,985
Chronic Renal Failure/ESRD, CHF, CHD, Dementia, Hypertension, Mental Illness	$51,344
Asthma/COPD, Chronic Renal Failure/ESRD, CHF, CHD, Dementia, Hypertension	$50,618
Chronic Pain, Chronic Renal Failure/ESRD, CHD, Dementia, Hypertension, Mental Illness	$50,327
Chronic Renal Failure/ESRD, CHF, CHD, Dementia, Hypertension	$47,453
Chronic Renal Failure/ESRD, CHF, Dementia, Hypertension	$45,342

Mental Illness and Drug/Alcohol Abuse As Co-Morbidities Are Major Cost Drivers



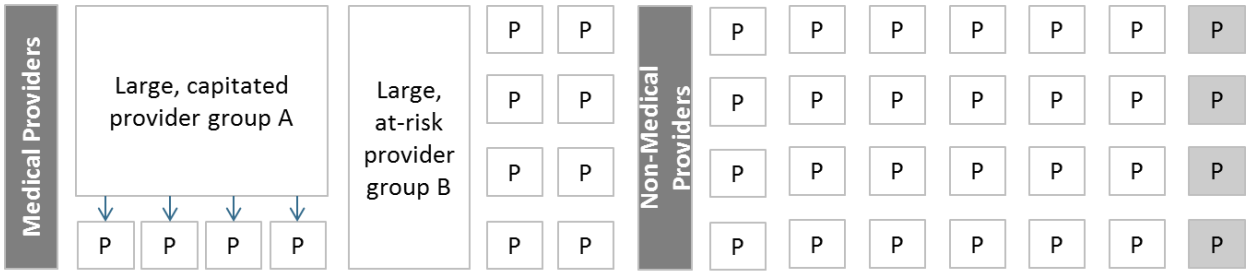
Source: CHCS, Clarifying Multimorbidity Patterns, Data Brief, Dec. 2010, which analyzed 1.9M non-dual adults with disabilities under 65 not including LTSS costs

Traditional case management approaches which rely heavily on mailings and phone calls are wholly insufficient for this population, as we know from our intensive work with more than 3,000 dual eligibles and those similarly situated. A dedicated field-based organization that engages the consumer, caregiver(s), and families is required. Through these methods and our use of information systems in the field, we have been reducing falls, preventing re-admissions, and predicting and lowering overall health care utilization since 2007.

To make matters more challenging, the providers that complex populations rely on have less capacity than traditional medical providers. As illustrated here, medical providers are better organized to take risk and implement quality improvement programs; non-medical providers are more fragmented.

Figure 2: Level of Organization of Medical and Non-Medical Providers Serving Duals

Medical Providers Well Organized Compared to Non-Medical Providers *(illus.)*



Further, in part due to their dependence on Medicaid as a payment source, non-medical providers are typically less well capitalized and less likely to use healthcare IT (in a central office or with their field-based staff).

As a result, many LTSS providers are strained to manage the consumers they serve effectively and efficiently, much less collaborate widely or seize one of their primary opportunities to impact care, which is the power of recommendation to consumers and physicians. Because of close contact and often trusted relationships with consumers and families, many LTSS providers have an opportunity to change consumer behavior to help meet goals and reduce the need for high-cost services.

This close relationship and deep insight into the consumer also provides an opportunity, similarly under-utilized, to influence physicians with timely recommendations. Physicians, because they write orders (e.g. for physical therapy or nursing facility admission), are a primary gateway to improving care and reducing costs. One of the primary goals of a new approach to care management must be to support LTSS providers as they go beyond delivering good, efficient care – a minimum requirement – into using their power of recommendation to influence a wider set of actors and resources.

In sum, due to the complexity of the population and the capacity of the non-medical provider community, it is time for a new approach to care management that will deliver higher quality, improved cost management, and greater consumer satisfaction and independence.

BRIEF, SPECIFIC COMMENTS ON RFI TOPIC AREAS

Populations to be included

All populations should be included in a full implementation. However, kids, adults with disabilities, and elders have fundamental differences in care needs, expectations, and services, and if smooth transitions can be ensured these populations should be separated (e.g. Massachusetts' forthcoming Duals Demonstration focuses on dual eligibles aged 21-64 years old).

Best enrollment model

Voluntary opt-in is the most consumer friendly means of enrollment. Over several years, most consumers should opt in to the managed model if it is effective in promoting independence and delivering <u>additional</u> benefits thanks to cost avoidance through improved prevention and care coordination.

Three practical considerations work against a voluntary opt-in model. First, some plans may be unwilling to invest in bidding on and managing a small initial business opportunity. Second, states may be unable to wait for the significant improvements in cost levels and cost predictability that

the managed care model should provide when applied to a large population. Finally, a voluntary opt-in increases the likelihood of adverse selection, either to plans or to the state depending on how the most complex consumers respond to the managed care offering.

Supports and services essential to include in the model

Ideally, all relevant medical, pharmaceutical, behavioral, and social services should be included in the scope of services to be coordinated by managed care. This would include Medicaid- and Medicare-paid services and resources provided outside of the CMS umbrella, such as SNAP (Department of Agriculture), religious and other charitable resources, and uncompensated family supports. Experienced bidders and their partners will seek to manage non-CMS resources and should be encouraged if not required to do so.

Medicare-paid services should be included so that states can benefit from the favorable impact of effective LTSS and behavioral health services on health care utilization. Practically speaking, the time required to negotiate a shared savings agreement between a state and CMS, and the final balance of savings, may not be worth insistence that Medicare as a payer be included in the first phase of a managed care model for complex consumers. We know some states such as Florida have started a managed LTSS initiative without including Medicare.

In our view, the essential core of services for a state-led managed care effort is facility- and community-based LTSS and behavioral health. Behavioral health is essential because it is a driving factor in acute and LTSS costs and quality. Facility-based long-term care must be included to provide an incentive to support consumer transitions back to the community and avoid facility placements and associated costs. This incentive will be strong where the capitation is based on level of need, not setting, so that plans and states can realize savings when a $5,000 a month nursing facility consumer returns to the community at a cost of $2,500 or less per month. Setting based capitation, as proposed in some states, will incent managed care plans to transition or avoid nursing facility placement only for the lowest need consumers.

Approach to conflict free case management

Conflict free case management is an important principle and a reasonable requirement in a fee-for-service environment. We believe strongly that information and referral sources should not be allowed to refer to their own provider services, in order to avoid the appearance and fact of self-interest.

Conflict free case management remains an important principle in managed care but its implementation is more challenging. The managed care company has a clear self-interest in managing care to lower costs, as does the state. This is usually the driving factor behind a recommendation to implement managed care. The question then is how to promote the interests that conflict free case management is intended to ensure: consumer protection and appropriate care.

We have observed five ways that states promote consumer protection and appropriate care in a managed care model:

- Effective and timely appeal and grievance processes
- Time-limited guarantee of continued provider relationships and services for beneficiaries upon enrollment, often for 90-180 days
- Quality reporting and financial incentive associated with quality; we are familiar with states from Tennessee to Rhode Island that have invested in quality, quality-based financial incentives, and, over time, re-procurement to ensure managed care companies focus on quality
- Benefit packages that include all necessary services and may include services such as peer supports, in which individuals with "lived experience" counsel and support fellow consumers
- Independent care coordinators; plans are required to contract with independent organizations or individuals whose role is to advocate for the consumer within the care team. The concept of an independent care coordinator is being developed now in the Massachusetts Duals Demonstration for individuals ages 21-64 years old, and the outcome of this design work and its practical effectiveness should be reviewed after this demonstration goes live on 7/1/2013.

We recommend that Louisiana evaluate these and other ways to ensure that the goals of conflict free case management, consumer protection and appropriate care, are met.

Inclusion of behavioral health

Behavioral health needs and services should be included in the scope of managed care responsibility as mental illness and substance abuse are highly correlated with increased medical and custodial costs.

How the system will use evidence-based best practices for treatment and patient care

Where standards are well-developed, as in acute care for relatively healthy populations, relevant standards should be applied and plans held accountable to them through reporting and financial incentives. In many areas of community-based care for complex consumers, the "right answer" is less well-developed. Plans should be charged with contributing to the development of new standards with thoughtful tracking of medical and non-medical risk factors, medical and non-medical interventions, and outcomes ranging from traditional measures to consumer independence and consumer, caregiver, and even family satisfaction.

Identify partnerships that might be formed

We view three types of partnerships as essential. First, and most obvious, is a partnership between the behavioral health manager and the managed care company responsible for acute and long-term care, if those services are managed separately. Second, most managed care companies, accustomed to managing care for TANF or "moms and kids" populations, will need to partner with

companies and community-based organizations with expertise in LTSS to be successful. Third, organizations that are accountable for meeting needs and delivering services must partner with families to be successful. Families in our experience are a source of insight into risk factors and the success of potential interventions; influence on behaviors which promote or detract from good outcomes; and tremendous hard work and dedication. Because families are not professionals and may be far from perfect, traditional managed care companies and even community-based organizations have shied away from, or at minimum under-utilized, family resources.

Education and outreach necessary prior to implementation

Enrollees, providers, and other stakeholders must all understand and contribute to a successful managed care initiative. Enrollees who are stable and well-served are likely worried about the ability to continue provider relationships and services on which they rely; enrollees who are not well-served now may wonder if managed care will make things worse or better. Providers are likely worried about their ability to continue providing and coordinating good care, and the rates to be paid and their inclusion or exclusion from networks.

These and other concerns need to be elicited and understood in a series of public meetings and calls for public input. Once understood, they can be addressed in design, implementation, and communication of the program.

Issues DHH should include in any Request for Proposals

DHH should consider all the issues we have addressed in these brief comments, specifically:

- Separating populations for managed care purposes based on different needs, and the need for smooth transitions by consumers between programs and plans
- Balancing consumer protections associated with enrollment methods and conflict free case management with the goals and practical limitations of managed care
- Broad inclusion of services including facility and community-based long-term care, behavioral health, non-CMS paid services, family and charitable resources
- Use of evidence-based practices where available, and development of new practices and standards based on data collected through the program
- The importance of partnerships with companies and community-based organizations with expertise in long-term care, particularly for bidders without significant experience in this area
- Enrollee, provider, and stakeholder engagement pre- and post-implementation
- Gradual transfer of risk from the state to managed care companies
- Capitation based on the consumer's level of need across medical, functional, behavioral health, and environmental needs (e.g. housing) and not based on setting (i.e. residence)

Evaluation of the success of the delivery model and over what time frame

In addition to measuring appropriate quality measures for the populations served and services included, DHH should evaluate:

- Actual versus projected cost to the state, including plan administrative costs, with the assumption that total costs over a three-year period should be no more than the projected claim costs of the population in the status quo
- Consumer enrollment and dis-enrollment in the delivery model overall and in specific plans. Even in a mandatory enrollment model, sometimes called voluntary opt-out, how consumers vote with their feet is an important indication of satisfaction along with explicit satisfaction survey results
- Explicit contributions by the plans to the knowledge of how to manage care for complex individuals. In other words, the program should build the base of evidence-based care on which Louisiana and other states and managed care organizations can build

Potential financial arrangements for sharing risk and rate-setting appropriate for population

Full risk should be avoided for at least the first two years of a program to lower the risk that losses force plans from the market; to mitigate the potential for out-sized plan gains in which the state does not participate; and to reduce the pressure on plans to cut provider rates, exclude providers from the network, and constrain consumer access to services to prevent financial losses. Instead, partial risk approaches, with shared upside and downside between state and managed care companies, should be adopted for at least the first two years of the program.

Plans should face penalties for withdrawing from the program during the contract period. Such penalties were part of the design of Florida MLTC, and yet there were still numerous well-regarded plans that bid on and won that business.

Capitation should be based on the best information available at launch about a consumer's needs, and should be adjusted within 90-180 days of launch with additional assessment data since most available data (e.g. claims data) is not sufficient to accurately profile plan enrollment by region, especially since those rating cells may be small. A setting-based capitation should be avoided. While this method helps protect facility-based providers from unfair rate cuts or network exclusions, there are other ways to protect these providers appropriately that do not undermine fundamentally the incentive to serve high need consumers in the community.

Timeline necessary for implementation

The timeline should accommodate significant enrollee, provider, and other stakeholder input. It should allow interested bidders to understand the population and market and prepare high quality bids. Finally, the post-award timeline should allow for adequate preparations by plans and outreach and education to enrollees. It may be helpful to conduct a rolling enrollment as some other states have done or plan to do (e.g. region 1 on January 1, region 2 on February 1, etc.). Realistic timelines should be set upfront so that delays can be minimized.

One factor to consider in the timeline is the development of the capitation methodology; shared savings approach (if any) with CMS and the Medicare program; rate setting; and rate negotiation if any. In some states, awards have been made before plans knew the rates they would be paid.

This introduces uncertainty for plans which may shrink the pool of bidders or breadth of bids (e.g. regions sought). It also leads to uncertainty for providers whose contracts in these circumstances will not specify rates or will give plans wide latitude to change rates based on the final capitation. Our recommendation, if possible, would be an approach in which plans know the rates and detailed rate methodology, or, an approach in which plans with sufficient quality are invited to negotiate over regions and rates.

Potential risks and benefits of the approach(es) proposed

Our responses have attempted to identify and mitigate the risks associated with managed care for complex populations. Specifically, among other features, we identify a need to balance:

- The opportunity to share in Medicare savings with the complexity and timeline associated with negotiating and implementing a dual eligible demonstration
- Unified management of services with the realities on the ground, for example, that the state has an existing behavioral health management organization and that most managed care organizations will need to contract with companies or community-based organizations with expertise in community-based long-term care
- Consumer choice and consumer protection – represented for example in voluntary opt-in and conflict free case management – with the goals and limitations associated with a move to managed care, such as the desire to incent multiple bidders and the express intent to reduce total costs versus projections over time

We identify a final risk given the complexities of the population in question. If a true coordinated care management approach is not pursued that focuses on identifying risk, sharing data, developing evidence-based programs and managing transitions of care, outcomes will be less desirable in terms of quality, cost management, and consumer satisfaction and independence.

OUR COMPANY AND OUR EXPERIENCE

Seniorlink was founded in 2000 by E. Byron Hensley who was a pioneer through his previous company, The Mentor Network, of the host home community-based model of care for adults with disabilities.

Seniorlink began with a focus on elders and the private sector and developed a national network of geriatric care managers. The network was made available as an employee benefit through Blue Cross Blue Shield Association plan members and large self-insured employers.

In 2005, Seniorlink began to leverage its private sector care management experience in the public sector, offering care management to a complex Medicaid population in a pilot program in Massachusetts called Caring Homes. The pilot program tested whether very frail elders could be effectively supported at home with a full-time, live-in family caregiver and professional team providing intensive care management. Seniorlink developed and deployed its first community care record software during this pilot. Today, we call the model Structured Family Caregiving (SFC).

The pilot was a success and the model became a Medicaid state plan service in 2007. Seniorlink now provides intensive care management through SFC to more than 1,800 complex consumers and their primary caregivers in three states (with a fourth opening in Q1 2013). The consumers Seniorlink serves, through its Caregiver Homes operating unit, typically require daily help with 3 of 6 activities of daily living, are behaviorally and medically complex, and are diverse in terms of age, ethnicity and language.

Through our community care record software, in continual development and use since 2007, we document consumer needs, interventions, and outcomes. The data collected has allowed us to develop proprietary risk screening. We continue to refine our comprehensive risk models and scores and update the rules engine which guides our clinicians as they respond to changes in a consumer's level and type of risk.

In 2011, we expanded our work to manage the portfolio of medical and non-medical resources that our consumers access through a statewide pilot in our Caregiver Homes of Rhode Island program. The pilot managed ordering, scheduling, and evaluation of a wide range of community services, all through our community care record. This pilot was successful and we are continuing and extending this service model and associated data and software development.

Fifteen percent of Seniorlink's consumers are enrolled as members with managed care organizations that are accountable for Medicaid and Medicare benefits. Seniorlink works today with two Senior Care Options (SCO) plans in Massachusetts, one a local, not-for-profit organization and the other the local division of a large, national for-profit. We also work with several PACE organizations in both Massachusetts and Rhode Island that are responsible for meeting member needs in a comprehensive way within a combined Medicare and Medicaid capitation.

Once again, we appreciate the opportunity to share our views and thank the Department for inviting comment on this important subject.